| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155377 | A. BUILDING 00<br>B. WING | 07/20/2011 |

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| WATERS OF SEYMOUR, THE | 707 S JACKSON PARK DR<br>SEYMOUR, IN47274 |

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| F0000 | This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00093557.<br><br>Complaint IN00093557 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey Dates: July 18, 19 and 20, 2011<br><br>Facility Number: 000272<br>Provider Number: 155377<br>AIM Number: 100274710<br><br>Survey Team:<br>Melinda Lewis RN TC<br>Sharon Whiteman RN<br>Marla Potts RN<br>Jill Ross RN<br><br>Census Bed Type:<br>SNF/NF: 87<br>Total: 87<br><br>Census Payor Type:<br>Medicare: 8<br>Medicaid: 70<br>Other: 9<br>Total: 87<br><br>Sample: 18 | F0000 | **PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL, OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan ofi correcton and specific correctve actons are prepared and/or executed in compliance with state and fiederal laws**<br>The ftacilitiy is requesting a DESK REVIEW oft compliance ftor tihis plan oft correction | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Supplemental Sample: 1<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review 7/22/11 by Suzanne Williams, RN | | | |
| F0248 SS=D | The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br>Based on observation, interview and record review, the facility failed to provide cognitively impaired residents ongoing activities, in that residents were observed to sit for long periods of time without benefit of any activity. This affected 2 of 5 residents reviewed for activities in the sample of 18.<br><br>Resident # 85 and 96<br><br>Findings include:<br><br>1. On 7/18/11 at 11:15 A.M., the Director of Nursing indicated Resident # 85 had a stroke and was receiving therapy services. Resident # 85 was not interviewable.<br><br>On 7/19/11 at 8:30 A.M., Resident # 85 was observed to be in bed on his right side. The television was observed to be on but Resident # 85's back was to the television. | F0248 | **F-248 ACTIVITIES** It is the intent of this facility to provide cognitively impaired residents with ongoing activities and not for them to sit long periods of time without benefit of any activity. A. **ACTIONS TAKEN**: 1. In regards to Resident # 85, the care plan will be reviewed and revised as necessary and the CNA assignment sheets updated. The activity program will be reviewed and revised to meet the needs of this resident. 2. In regards to Resident # 96, the care plan has been reviewed and revised as necessary and the CNA assignment sheets updated. The activity program will be reviewed and revised to meet the needs of this resident. B. **OTHERS IDENTIFIED**:1. 100% audit of all cognitively impaired residents and their activity program will be completed. The activity program will be reviewed and revised for each cognitively impaired resident to meet their individual | 08/18/2011 |

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| | On 7/19/11 at 10:15 A.M., Resident # 85 was observed to be in bed on his back. The television was on.<br><br>On 7/19/11 at 1:00 P.M., Resident # 85 was observed to be assisted up to a wheelchair. Resident # 85 remained in his room sitting in front of the television.<br><br>The clinical record for Resident # 87 was reviewed on 7/19/11 at 9:00 A.M. The record indicated Resident # 87 had diagnoses that included but were not limited to stroke, right hemiparesis, and expressive aphasia. The MDS [minimum data set] assessment, dated 5/5/11, indicated Resident # 85 had moderately impaired cognition. Resident # 85 required extensive assistance of two with bed mobility and transfers. Resident # 85 did not ambulate.<br><br>The Activity Assessment, dated 2/15/11, indicated for Resident # 85 "...Any item marked below is an indicated that the resident, family/significant other considers it wither very important or somewhat important...sports magazines, country music, blue grass, likes all animals, enjoys reading newspaper and local news on TV, enjoys motorcycle riding, outdoors, enjoys fishing, family outings, traveling...per interview with | | needs. C. **MEASURES TAKEN**: 1. Activities staff were in-serviced on meeting the social and activity needs of a cognitively impaired resident including: appropriate tracking and documentation, 1 on 1 activity, sensory stimulation programs. D. **HOW MONITORED**: 1. Activity Director/Designee will complete a daily audit for 30 days; weekly audit for 90 days; quarterly audit thereafter; of the activities provided for all cognitively impaired residents. 2. The IDT will monitor/audit the activities program as part of the Daily QA Rounds and reviewed daily in the daily Stand-up QA Meetings. 3. The CEO/Designee will review these audits as completed. All audits will be reviewed in the quarterly QA Meeting with the Medical Director. E. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 18, 2011.** | |

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| | POA [Power of Attorney] (Resident # 85) very active until recent (stroke)..."<br><br>The care plan, dated 4/5/11 and updated on 4/15/11 and 5/13/11, indicated a problem of "I make independent activity decisions. I am able to initiate leisure activities of my choice. I enjoy: fishing trips, music, outdoors, TV, current events, sports, motorcycles, and socializing." The interventions were "1. Provide me with a monthly activity schedule. 2. Invite and encourage me to participate in group activities of my potential interest. 3. Encourage me to pursue leisure activities of my interest. 4. Assist me with leisure pursuits by supplying materials as needed. 5. Honor my preferences. 6. Offer me choices. 7. Provide me with small group activities twice a week."<br><br>The MDS 3.0 Activity Progress Note, dated 5/5/11, indicated "...During observation period resident declined to participate in group activities. No change in participation level...Independent leisure pursuits include: reading, watching TV. listening to music, playing checkers, visiting with friends and family...Resident refused to participate in small group activities during observation period...C/P [care plan] focuses on participation in group activities 1 x [time] week and small group 2 x week, leisure pursuits daily. | | | |

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| | Resident declined group activities and refused sm [small] group. Resident doing well on leisure goal. Will continue to invite and encourage to attend activities of potential interest..."<br><br>The July 2011 Activity Group Attendance Record indicated Resident # 85 had refused all activities offered for the month.<br><br>The July 2011 Independent Activity Tracking Log indicated Resident # 85 had visitors on 7/3, 7/10, 7/11, 7/15, 7/17. and 7/18/11. Resident # 85 had TV and music daily the entire month.<br><br>On 7/19/11 at 4:00 P.M., an interview with the Activity Director indicated Resident # 85 had been on one to one activities for a short time but did not participate.<br><br>2. On the initial tour, on 7/18/11 at 11:15 A.M., the Director of Nursing indicated Resident # 96 was not interviewable.<br><br>The clinical record for Resident # 96 was reviewed on 7/19/11 at 12:30 P.M. The record indicated Resident # 96 had diagnoses that included but were not limited to dementia and agitated depression. The MDS [minimum data set] assessment, dated 4/11/11, indicated | | | |

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| | Resident # 96 had severe cognitive impairment. Resident # 96 was independent with ambulation.<br><br>The Activity Care Plan, dated 1/18/11 and updated on 2/10/11 and 5/20/11, indicated a problem of "I make independent activity decisions. I am able to initiate leisure activities of my choice. I need reminders to attend activities of my interest. I enjoy: bingo, TV, music, socials, parties, spirituals, and visits with friends and family." The interventions were "1. Provide me with a monthly activity schedule. 2. Invite and encourage me to participate in group activities of my potential interest. 3. Encourage me to pursue leisure activities of my interest. 4. Assist me with leisure pursuits by supplying materials as needed. 5. Honor my preferences. 6. Offer me choices."<br><br>The June 2011 Activity Attendance Record indicated Resident # 96 attended one activity with all other activities declined or was asleep for the month of June.<br><br>The June 2011 Independent Activity Tracking Log indicated Resident # 96 had received mail on 6/14/11. Resident # 96 had television and music everyday except 6/4/11 and 6/5/11. | | | |

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| | The Activity Progress Note, dated 7/6/11, indicated "...Enjoys magazines, socializing, going outdoors and attending church...During observation period resident declined to participate in group activities...Independent leisure pursuits include: watching TV, socializing with peers around nurses station...C/P [care plan] focuses on participation in group activities 1-2 x [times] week and leisure pursuits daily. Resident doing well on leisure goal, will continue to invite and encourage to attend activities of potential interest..."<br><br>The July 2011 Activity Attendance Record indicated Resident # 96 had attended two activities from 7/1 to 7/18/11.<br><br>The July 2011 Independent Activity Tracking Log indicated Resident # 96 had television everyday from 7/1 to 7/18/11.<br><br>In an interview with the Activity Director, on 7/19/11 at 4:00 P.M., she indicated Resident # 96 would always refused when asked to attend activities. | | | |
| F0252 SS=B | 3.1-33(a)<br>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. | | | |

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| | Based on interview and observation, the facility failed to ensure 1 of 4 resident units were maintained in a homelike manner, in that paint was marred on doors, metal heaters were rusted, holes were observed around an exit door and bathroom shower areas had a black substance along the edges. This had the potential to affect all 21 residents who resided on the C hallway from the facility census of 87.<br><br>Findings include:<br><br>On 7/19/11 at 4:30 P.M., on a tour of the building with the Administrator, Maintenance Director, and Housekeeping Supervisor the following was observed:<br>-All the resident room doors on the C wing were observed to have been scratched and have deep scrapes.<br>-A small wall heater next to the exit door on the C wing short hall was observed to be rusty.<br>-The exit door on C wing short hall was observed to have a gap at the bottom where sunlight was visible.<br>-The C wing shower room floor was observed to have a black substance in the corners with some of the tiles coming loose.<br>-The B wing nurses station was observed to have a hole at the front of the desk. | F0252 | **F-252 ENVIRONMENT** The facility's intent is to maintain a homelike environment without paint marred on doors, metal heaters without rust, no holes around exit doors, and clean shower rooms.A. **ACTIONS TAKEN**: 1. All doors to Resident rooms were repaired. 2. Small wall heater next to the exit door on the C wing short hall was repaired. 3. The gap at the bottom of the exit door on C wing was repaired. 4. The shower room floor on C wing was cleaned and tiles repaired. 5. The B wing nurses station was repaired. B. **OTHERS IDENTIFIED**: 1. 100% audit of all Residents Room doors to identify any requiring repair. No other resident room doors were identified. 2. 100% audit of all heaters for any needed repairs. Any identified will be repaired.3. 100% audit of all exit doors for gaps. No other doors identified.4. 100% audit of all shower rooms for cleanliness and tiles in good repair. No others were identified. C. **MEASURES TAKEN**: 1. All Staff was re-in-serviced on reporting required/needed repairs to the CEO/Maintenance Director. D. **HOW MONITORED**: 1. The Maintenance Supervisor/Designee will audit resident doors, showers, heaters, and the overall facility surroundings quarterly for any needed/required repairs. This will be an on-going QA program. 2. | 08/18/2011 |

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| | In an interview with the Administrator, on 7/19/11 at 5:15 P.M., he indicated they had done some remodeling on A wing, B wing and D wing.<br><br>3.1-19(f) | | The CEO/Designee will monitor for compliance of these repairs in daily QA stand-up meeting. 3. All facility repairs will be reviewed in the quarterly Safety Committee for completion, and the quarterly QA meeting with the Medical Director. **E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is: 8-18-11.** | |
| F0279 SS=D | A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br>Based on interview, observation and record review, the facility failed to ensure a care plan was developed for a lap tray restraint, to ensure it was used for the least amount of time possible, for 1 of 1 resident reviewed for restraints in the supplemental sample of 1. | F0279 | **F-279 COMPREHENSIVE CARE PLANS**<br>The ftacilitiy's intienti is tio develop a plan oft care ftor a lap tiray restirainti tio ensure iti is used ftor tihe leasti amounti oft time possible<br><br>A. **ACTIONS TAKEN**: | 08/18/2011 |

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| | Resident #17<br><br>Findings include:<br><br>Resident #17 was observed on 7/19/11 at 11:30 A.M. sitting in the dining room with a lap tray restraint on her wheelchair.<br><br>Resident #17's clinical record was reviewed on 7/19/11 at 2:15 P.M. The Minimum Data Set assessment, dated 4/11/11, indicated the resident was severely cognitively impaired, required assistance with transfers and did not ambulate. The MDS indicated Resident # 17 did not utilize restraints.<br><br>A telephone physician order, dated 7/6/11, indicated "lap tray for safety related to falls and is used as a restraint." The resident's current care plan did not include a plan for the lap tray.<br><br>During interview with the Director of Nursing on 7/19/11 at 2:00 P.M. she indicated the resident was to have the lap tray on while up in the wheelchair. She indicated she would have to talk with the unit manager about a care plan. When asked about any plans for reduction or to have her out of the restraint, the DON indicated she would be reassessed each quarter. | | 1. Residenti# 17: The lap tiray was removed and a Tilti drop seati witih a selft release alarmed seati belti was puti intio place(This is noti a restiraintj; a plan oft care was developed ftor tihe Tilti drop seati belti witih tihe selft release alarmed seati belti.<br><br>B. **OTHERS IDENTIFIED**:<br><br>1. 100% auditi oft all Residentis witih any tiype oft restiraintj tio ensure iti is used ftor tihe leasti amounti oft time possible. No otiher restiraintis were identifted.<br><br>C. **MEASURES TAKEN**:<br><br>1. All Licensed Stiaft were in-serviced on Care Plan developmenti and revision in regards tio restiraintjs:assessmentj time on, time oft, documentiationj and reduction.<br><br>D. **HOW MONITORED**:<br><br>1. The IDT will review/revise residenti care plans after quartierly assessmentj and prn, and during tihe care plan confterence witih tihe residentj/ ftamily This will be an on-going QA program.<br><br>2. The DON/Designee will review/revise residenti care plans witih new orders and change oft | |

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| | On 7/19/11 at 4:00 P.M., Unit Manager #1 indicated the care plan for the resident's lap tray was in her office and had failed to be placed on the resident's chart. The Unit Manager provided a care plan dated 7/6/11 for "resident uses lap-tray, to prevent rising, as reminder to call for assist." Approaches included: release every 2 hours and prn (as needed) toileting, dressing shower, etc, assist prn for transfer, encourage to move arms, legs during transfer and dressing, quarterly restraint reduction review. Written in and dated 7/19/11 was "resident to be free of lap tray during supervised activities."<br><br>The policy and procedure for "Restraint Assessment and Reduction", dated 1/07, indicated "Residents who require the use of restraints are to have a care plan developed which outlines the methods and goals to reduce its use/prevent complications from the use..."<br><br>3.1-35(b)(1) | | condition.<br><br>3. The CEO/Designee will monitior ftor compliance in daily QA stiand-up meeting; and quartierly in QA meeting witih tihe Medical Directior.<br><br>E. **This plan ofi correcton consttutes our credible allegaton ofi compliance with all regulatory requirements, out date ofi completon is : 8-18-2011.** | |
| F0322 SS=D | Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. | | | |

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| | Based on observation and record review, the facility failed to ensure a resident with a gastrostomy tube had the head of his bed elevated 30 degrees as indicated in his care plan. This finding included 1 of 1 resident reviewed for gastrostomy tube in a sample of 18. (Resident #85)<br><br>Findings Include:<br><br>On 07/18/11 at 12:35 p.m. and 5:00 p.m. Resident #85 was observed resting on his bed with the head of his bed in flat position.<br><br>On 07/19/11 at 8:30 a.m., 10:15 a.m., 10:35 a.m., 12:15 p.m., and 4:00 p.m. Resident #85 was observed resting on his bed with the head of his bed in flat position.<br><br>Review of Resident #85's clinical record on 07/19/11 at 5:00 p.m. indicated the following:<br><br>Resident #85 had diagnoses which included, but were not limited to, stroke, dysphagia (swallowing problems), PEG (percutaneous endoscopic gastrostomy) tube placement for delivery of hydration and medications, and expressive aphagia (difficulty speaking).<br><br>The Current physician order, dated 7/1/11, | F0322 | F-322 NG Treatment/Services-Restore Eating SkillsIt is the intent of the facility to ensure a resident with a gastrostomy tube has the head of the bed elevated 30 degrees.A. ACTIONS TAKEN: 1. In regards to Resident # 85, the risers were placed on the bed to maintain a 30 degree elevation of the head of the bed. (The risers were in the building, but had not been put in place.)B. OTHERS IDENTIFIED: 1. 100% audit was completed of all residents with a gastrostomy tube for elevation of the head of the bed at 30 degrees. No other residents were identified. C. MEASURES TAKEN: 1. All nursing staff were in-serviced on facility policy for maintaining the head of the bed at 30 degrees for all residents with a gastrostomy tube. D. HOW MONITORED: 1. D.O.N./Designee will audit all residents with a gastrostomy tube weekly x one week; monthly x three months; and quarterly thereafter to ensure risers are in place per policy. 2. The CEO/Designee will review all audits as completed in the daily QA stand-up meeting; and monthly in the QA meeting; and quarterly with the Medical Director in the QA meeting.**E. THIS PLAN OF CORRECTION CONSTITUTES OUR CREDIBLE ALLEGATION OF COMPLIANCE WITH ALL REGULATORY REQUIREMENTS. OUR DATE** | 08/18/2011 |

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| | indicated "Glucerna 1.5 at 80 cc per hour from 7:00 P.M.. to 5:00 A.M."<br><br>A care plan, dated 02/18/11 with most recent update of 07/08/11, indicated, "Potential for complications relative to peg tube feeding." The goal of this care plan indicated, "Resident's (Resident #85's) G-tube (peg tube) will remain patent and resident will maintain weight of ....without complications such as nausea, vomiting, constipation, diarrhea, aspiration, or G-tube site infection on a daily basis thru next review." Interventions for this care plan included, but were not limited to, "Elevate head of bed 30 degrees at all times."<br><br>3.1-44(a)(2) | | **OF COMPLIANCE IS: 8-18-11.** | |
| F0332 SS=D | The facility must ensure that it is free of medication error rates of five percent or greater.<br>Based on observation and record review, the facility failed to ensure it was free from an error rate of greater than 5% during medication pass observation. This finding is related to 3 errors made during a total of 42 medications observed being administered. This resulted in an error rate of 7.14% for 3 of 10 residents observed during medication pass. (Resident #105, Resident #98, and Resident #60. | F0332 | **F-332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE** The intent of this facility is to be free from an error rate of greater than 5% during medication pass observation. **A. Actions Taken**: 1. In regards to resident #105: the doctor was contacted and the dose was clarified. LPN # 1 was counseled and in-serviced on the correct way to administer an inhaler per MD orders<br>2. In regards to resident #98: | 08/18/2011 |

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| | Findings Include:<br><br>During observation of medication pass on 07/18/11 the following observations were made:<br><br>1. On 07/18/11 at 12:05 p.m., LPN #1 was observed to hand a Ventolin inhaler (breathing treatment) to Resident #105. The resident was observed to place the inhaler in his mouth. LPN #1 told the resident "Just 2" puffs.<br><br>Resident #105 was observed to administer 2 puffs of the Ventolin inhaler to himself.<br><br>Review of Resident #105's clinical record on 07/19/11 at 4:00 p.m. indicated the following:<br><br>A physician's re-write order for July, 2011 included and order, dated 02/09/11, for Ventolin HFA 90 micrograms - 1 puff to be administered 3 times a day for chronic obstructive pulmonary disease.<br><br>2. On 07/18/11 at 12:10 p.m., LPN #1 was observed to administer 10 milligrams of Metoclopramide (medication often used to treat nausea and indigestion) to Resident #98. Interview of Resident #98 at that time indicated the resident had already eaten his lunch. | | LPN # 1 was counseled and in-serviced on following MD orders when administering medications.<br>3. In regards to resident # 60: LPN # 2 was counseled and in-serviced on the correct procedure and instructions for a resident when administering and assisting with an Advair 250-50 Diskus. **B. Others Identified**: 1. 100% audit of all residents who receive a hand held inhaler, medications to be administered before/after meals, and an Advair Diskus, to ensure the dosage was correct and the MD's orders are followed when administered.<br>2. 100 % audit of all residents who receive hand held inhaler medications to be administered and ensure the order reads rinse and spit after administration.<br>**C. Measures Taken**:<br>1. All nursing staff will be educated/in-serviced on the correct procedure for administering medication, the 5 rights of a medication administration, how to document, appropriately giving resident instructions, and following the MD's orders for administration of all medications.<br>**D. How Monitored**: 1. DON/Designee will do a 100% audit/observation of each nurse during a medication pass; to identify issues/concerns and ensure competency. Then one random nurse will be observed daily on each shift x one week; | |

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| | Review of Resident #98's clinical record on 07/18/11 at 4:10 p .m. indicated the following:<br><br>A physician's re-write order for July, 2011 included an order, dated 08/31/08, for Metroclopramide 10 milligrams to be give before meals and at bedtime for diagnosis of Gastroesophageal Reflux Disease.<br><br>3. On 07/18/11 at 3:30 p.m., LPN #2 was observed to administer Advair 250-50 Diskus - 1 puff to Resident #60. LPN #2 was observed to not instruct the Resident nor assist her to rinse her mouth after administering the breathing treatment.<br><br>Review of Resident #60's clinical record on 07/18/11 at 4:15 p.m. indicated the following:<br><br>A physician's re-write order for July, 2011 included an order, dated 04/23/11, for Advair 250-50 Diskus - Inhale 1 puff by mouth 2 times daily for diagnosis of chronic obstructive pulmonary disease.<br><br>A copy of an instruction sheet for the Advair Diskus was provided by LPN #2 on 07/19/11 at 11:15 a.m. The instruction sheet indicated, "...Rinse your mouth with water after using Advair Diskus. | | then one random nurse will be observed weekly on each shift x one month; then one random nurse will be observed monthly on each shift x three months; the QA team will determine whether to continue or end this process at that time<br>2. The CEO/Designee will review all audits as completed in the daily QA meeting; all audits will be reviewed in the monthly QA meeting; all audits will be reviewed with the Medical Director in the quarterly QA meeting.<br>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: 8-18-11. | |

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| F0333 SS=D | 3.1-25(b)(9)<br>3.1-48(c)(1)<br>The facility must ensure that residents are free of any significant medication errors.<br><br>Based on interview and record review, the facility failed to ensure residents were free from significant medication errors, in that insulin was given twice due to staff failure to check the Medication administration record prior to administration, for 1 of 27 residents reviewed for medications during clinical record review and the medication pass observation, in the sample of 18, and 9 additional residents reviewed during the medication pass. Resident #92<br><br>Findings include:<br><br>1. Resident #92's clinical record was reviewed on 7/18/11 at 11:00 A.M. Diagnoses included, but were not limited to: diabetes mellitus and dementia. Physician recap orders dated 6/30/11, included an order for "Levemir Flexpen (insulin, used to treat diabetes by lowering blood sugar levels) inject 120 units sub-q every a.m."<br><br>Nurse notes indicated: "7/2/11 0830 after giving scheduled dose of Levemir insulin at 0645 this a.m., writer went to sign off MAR and noted it had been signed by noc (night) shift nurse. Writer called said nurse to confirm if insulin had in fact | F0333 | **F-333 RESIDENT FREE OF SIGNIFICANT MEDICATION ERRORS** The intent of this facility is for residents to be free of significant errors and the nursing staff will follow the medication administration record prior to, and after administering any medication. **A. Actions Taken**:1. In regards to resident #92: the doctor was contacted and orders were received and noted.The nurse was counseled and in-serviced on: checking the medication with the MAR three times prior to administering any medication, use of the medication administration record prior to, and after administering any medication. There was no negative outcome for the resident.B. Others Identified: 1. 100% audit of all residents who receive insulin, to ensure the dosage was correct and the MD's orders are followed when administered. C. Measures Taken: 1. All nursing staff will be educated/in-serviced on the correct procedure for administering medication, the 5 rights of a medication administration, how and when to document on the MAR (medication administration record), checking the medication three times prior to administering | 08/18/2011 |

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| | been given or if MAR (medication administration record) had been initialed accidentally. Night shift nurse stated she had given dose. Writer immediately notified Medical director on call .. and initiated blood sugar checks every 2 hours..."<br><br>The policy and procedure was provided on 7/18/11 at 1:00 P.M., by unit manager #1, for "General Guidelines for Administering Medication., dated 7/26/06." The policy indicated "The MAR (medication administration record) is initialed by the person administering a medication in the space provided...prior to administration, the medication and dosage schedule on the resident's MAR is compared the medication label....The nurse will check the medication name, strength, route and dose that are on the prescription label against the MAR and assure that the information on the unit dose package matches. The nurse is the final check in prevention medication errors and it is his/her responsibility to assure very medication administer is correct. The nurses should check the medication three times before administering to the resident..."<br><br>During interview with the Director of Nursing and Assistant Director of Nursing on 7/18/11 at 1:00 P.M. they indicated the | | it, appropriately giving resident instructions, and following the MD's orders for administration of all medications.D. How Monitored: 1. DON/Designee will do a 100% audit/observation of each nurse during a medication pass; to identify issues/concerns and ensure competency. Then one random nurse will be observed daily on each shift x one week; then one random nurse will be observed weekly on each shift x one month; then one random nurse will be observed monthly on each shift x three months; the QA team will determine whether to continue or end this process at that time.2. The CEO/Designee will review all audits as completed in the daily QA meeting; all audits will be reviewed in the monthly QA meeting; all audits will be reviewed with the Medical Director in the quarterly QA meeting. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: 8-18-11. | |

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| | time for the medication was changed to later to ensure only day shift would give, and agreed the nurse had given the medication without checking the MAR first.<br><br>3.1-25(b)(9)<br>3.1-48(c)(2) | | | |
| F0368<br>SS=B | Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.<br><br>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.<br><br>The facility must offer snacks at bedtime daily.<br><br>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.<br>Based on interviews, the facility failed to ensure bed time snacks were offered to each resident daily, for 7 of 7 residents interviewed in the group meeting. This has the potential to affect all residents who reside within the facility. Resident #4, 38, 34, 51, 67, 2 and 24.<br><br>Findings include:<br><br>During the group meeting on 7/19/11 at | F0368 | **F-368 FREQUENCY OF MEALS/SNACKS AT BEDTIME**<br>It is the intent of this facility for all residents to be offered a bed time snack daily. A. **ACTIONS TAKEN**: 1. In regards to Residents #4, #38, #34, #51, #67, #2, and # 24: each resident, as well as all other residents, are offered a bed time snack every evening and tracking is now in place to monitor. B. **OTHERS IDENTIFIED**: 1. 100% audit was completed of all residents for | 08/18/2011 |

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| | 1:00 P.M., with 7 residents identified by the Activity Director as interviewable. 7 of 7 residents attending indicated they were not routinely offered bedtime snacks. Some indicated that the were once in a while and that the kitchen brought trays out with snacks but the snacks did not get offered or whoever went and took snacks off the trays got them.<br><br>During interview with the Dietary Manager on 7/18/11 at 4:00 P.M. she indicated dietary staff took a tray of snacks to each unit for bedtime snacks, but nursing passed them out and she did not know what residents took snacks.<br><br>During interview with the Director of Nursing on 7/19/11 at 5:45 P.M. she indicated the facility did not document routine snacks provided to the residents, but would start doing so.<br><br>3.1-21(e) | | receiving a bed time snack. This would have the potential to affect all residents. C. **MEASURES TAKEN**: 1. Dietary staff were educated/in-serviced to facility policy in regards to the importance of ensuring bed time snacks were provided daily. 2. Charge Nurse/Designee will audit/review all bed time snack records daily to identify any resident who does not receive or is not offered a bed time snack. D. **HOW MONITORED**: 1. D.O.N./Designee will review all bed time snack records daily in the QA stand-up meeting. 2. The CEO/Designee will review these audits in the quarterly in the QA meeting with the Medical Director. E. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is:** 8-18-11. | |